Dropped

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Thud. I'm not sure if it was the loud thud or my 8-month old's piercing cry that woke me up that morning. It was the fourth and final night that I was alone while my husband was away and neither of our young daughters had been sleeping well. I found my little one on the floor beside the bed, looking up at me with her big brown eyes. I quickly picked her up and she let out a few more whimpers before soothing herself back to sleep while breastfeeding in my lap, leaving me to try to piece together what had happened. We fell asleep in my bed after our last feed. She had an unwitnessed fall from 3 feet. I didn't know what my daughter hit on her way to the floor. A few minutes later—what felt like a decade—she woke up. I had been trained to evaluate these cases in the pediatric emergency department and was relieved to see her pupils were symmetric, she had no palpable skull fracture or bruising, no vomiting, and she was acting totally normally. I observed her every move closely for the next few hours, which she spent crawling after her big sister and eating everything in sight.

By that evening, our daughter seemed to have long forgotten her big thud. So, I didn't even mention it to my husband when he came home, surely a combination of shame, embarrassment, and wanting to forget it had ever happened. We went back to our routine—he largely dealt with our oldest daughter's nighttime wake ups and helped to return our infant safely back to her crib after a nighttime feed.

In the coming weeks, I actually forgot about the drop, until I received a phone call about one of my primary care patients, G*. He was 6 weeks old and lived with his mother* at a substance use treatment program. G was this mother's fifth child; she had breastfed each of her older kids, several for over a year, and she was committed to breastfeeding this time too. G was opioid exposed during pregnancy and was a fussy newborn who struggled to gain weight. He was tough to console in clinic where we saw him every 2 to 3 days to monitor his weight for the first few weeks. His mom had taken to putting him on her chest at night in her bed, hoping even for a moment of sleep. The staff at the residential treatment program warned G's mother that co-sleeping was not safe and that her baby had to be put down in his bassinet. During the following nights, someone would enter this family's room every few hours, shining a flashlight on mom and baby to make sure that G was not in her arms. One night, program staff found them together and reported the incident to the Department of Child and Families, our state's child welfare agency.

The staff at the treatment facility shared with me that they could not tolerate any risk of mom harming her infant under their watch, so they would continue to ensure the baby was safe multiple times a night. Mom had experienced past trauma and had postpartum psychosis with her prior pregnancy, making sleep difficult at baseline and a sense of privacy and safety extra important. Yet, the response to her co-sleeping due to utter exhaustion was not additional support or reprieve from the challenges of parenting a fussy infant alone night after night, but rather increased surveillance and scrutiny. This response is not dissimilar to our medical approach when people are using nonprescribed substances. We ask patients to increase their frequency of visits to the clinic, we shorten the length of their prescriptions, and many providers will drop patients if they are unable to meet this increased level of monitoring, at a moment when they actually are struggling the most.

It was only then that my daughter's big thud came crashing back. I had not only put my daughter at risk when she fell asleep in my bed, but I had actually caused harm. Should I have been reported to the Department of Child and Families? If I had brought my daughter into the emergency department to be evaluated, how would I have been treated? It is hard not to compare my experience to G's mom, who faced relentless challenges on her own. In contrast, I have a supportive partner who shares at least half of the load, family close by who routinely babysit so we can get a full night's sleep, not to mention the privilege afforded to me by the color of my skin and professional attainment.

In my clinical practice caring for substance-exposed families, I admit I am often relieved when I learn that a mother and infant are staying at a residential treatment program. There will be structure, supervised groups, and more eyes watching over them. I encourage and refer families to receive visiting nursing, early intervention, and in-home maternal-infant mental health therapists. These are needed services and also add someone else to share in my "risk" of caring for families impacted by addiction. Yet

the families I care for often want to leave these programs and decline in-home services. Some parents tell me that too often these programs and services feel like more surveillance and not like support.

I often ask myself what a supportive system could actually look like. As a pediatrician, I am trained to identify potential risks and to advocate for the health and well-being of infants who cannot care for themselves. But how do we also weigh the potential harm to the dyad or to the mother from the constant scrutiny that these families experience? Rather than risking splitting families apart, what if we thoughtfully identified families' real needs and addressed them with robust services? What if we intensified childcare services, offered a night nanny, brought in a parent coach, or hired someone to help cook and clean? What if when parents are struggling the most, we provided supportive homes for the dyad, to care not just for the infant but also nurture the struggling parent?

Until we are able to treat women and families humanely and with dignity, how can we expect people to be forthcoming when many of us are struggling? If we truly set people up to succeed rather than waiting for them to fail, perhaps women would feel they can express their vulnerabilities, rather than trying to hide them from medical and behavioral providers. I didn't want to tell anyone about my own daughter's fall, not even my husband. Yet when I have mustered the courage to share my story with a few colleagues and mentors, many have also disclosed their own similar scares.

I do not intend to minimize the real harm that can result to children while their parents are in the throes of active addiction, mental illness, or just severe sleep deprivation. Nor do I want to diminish the effort of our community partners and child welfare agencies to care for vulnerable dyads. But I also see families harmed when we ask women with substance use disorder with minimal supports to jump through superhuman hoops. During just a few days of caring for my children on my own, I wasn't able to safely navigate those expectations. Instead of our health care and social service systems shining bright lights on families and then dropping them when they need us most, we need to redirect our resources to provide G and his mom the deep support they deserve.

*Names and some details have been altered to protect identities. In addition, the parent in this piece gave the author permission to share this story.

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